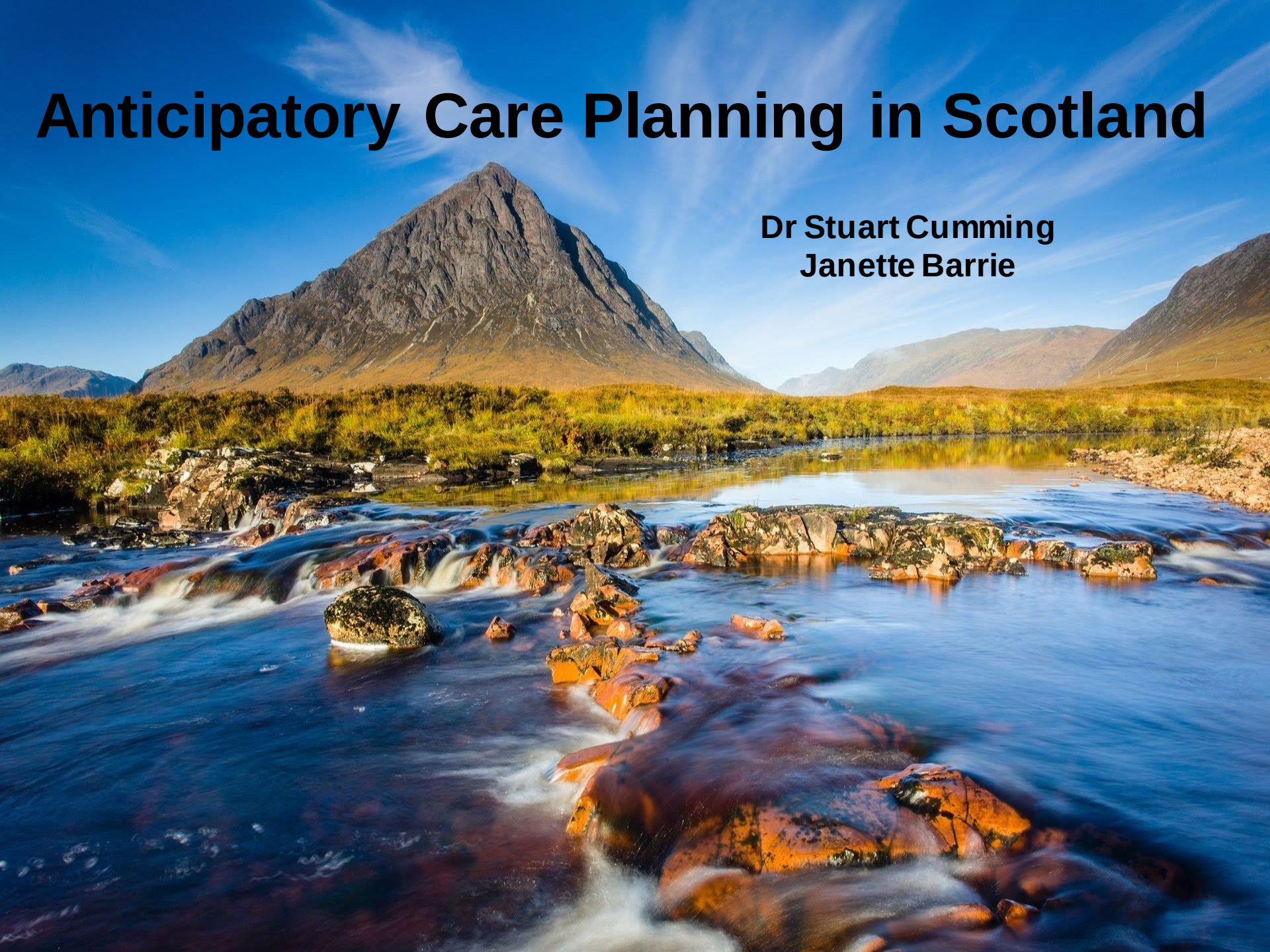
Anticipatory Care Planning in Scotland



Dr Stuart Cumming
Janette Barrie

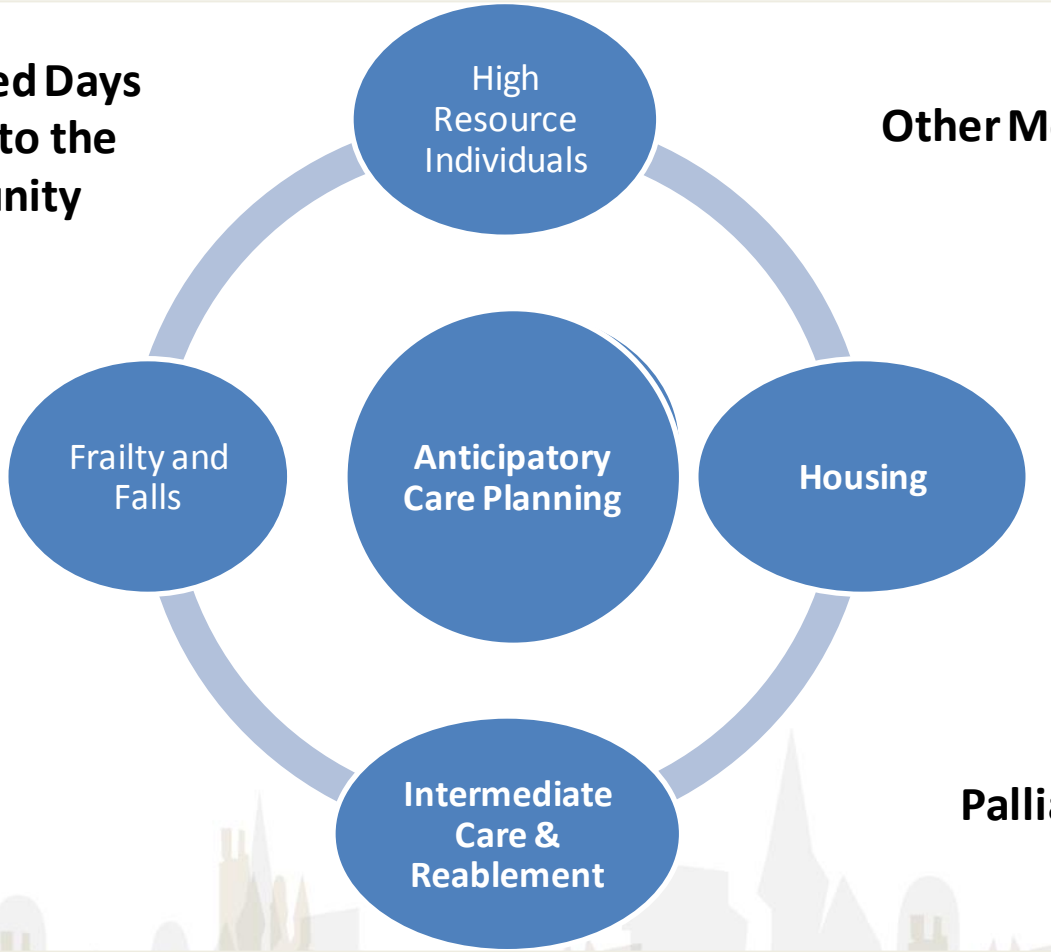
Anticipatory Care Planning

Time to make it happen: Planning for success

Living Well In Communities

200,000 Bed Days returned to the community

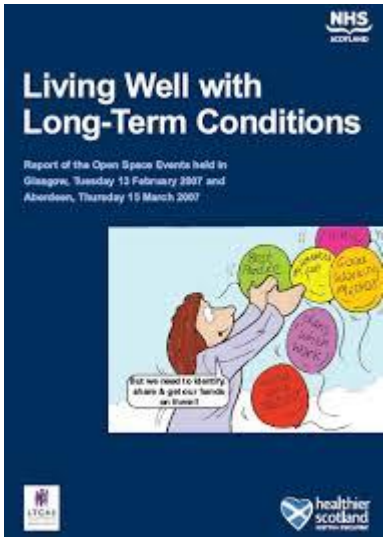
Other Models of Care

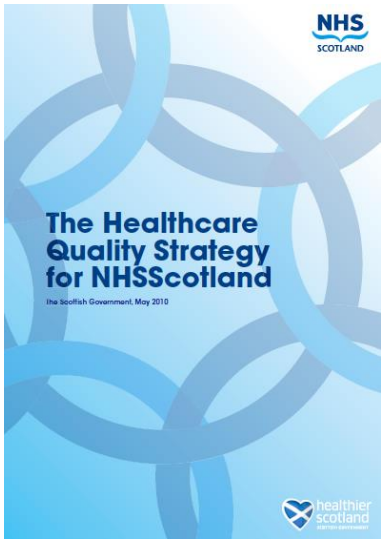


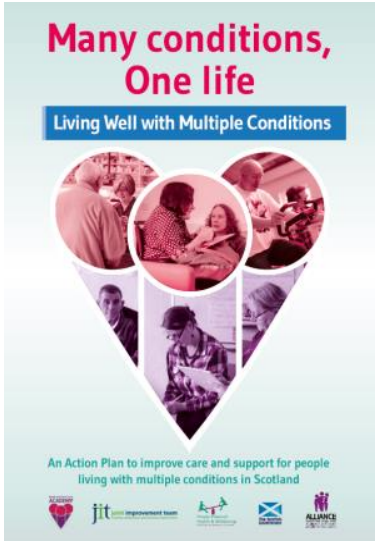
Dementia

Palliative Care

Background and Landscape







- Long Term Conditions Collaborative
- Reshaping Care for Older People
- Many Conditions, One Life Action Plan
- ACP Task & Finish

- 2020
- Christie Commission
- Health and Social Care Integration
- Health and Wellbeing Outcomes

What is Anticipatory Care Planning?

“Thinking ahead" and working with people and those close to them to set and achieve common goals in an ongoing process that will ensure the right thing is being done at the right time by the right person(s) with the right outcome

Consider ACP approach for 5-6% of population

2% of population use 77% of bed days (90% unplanned)

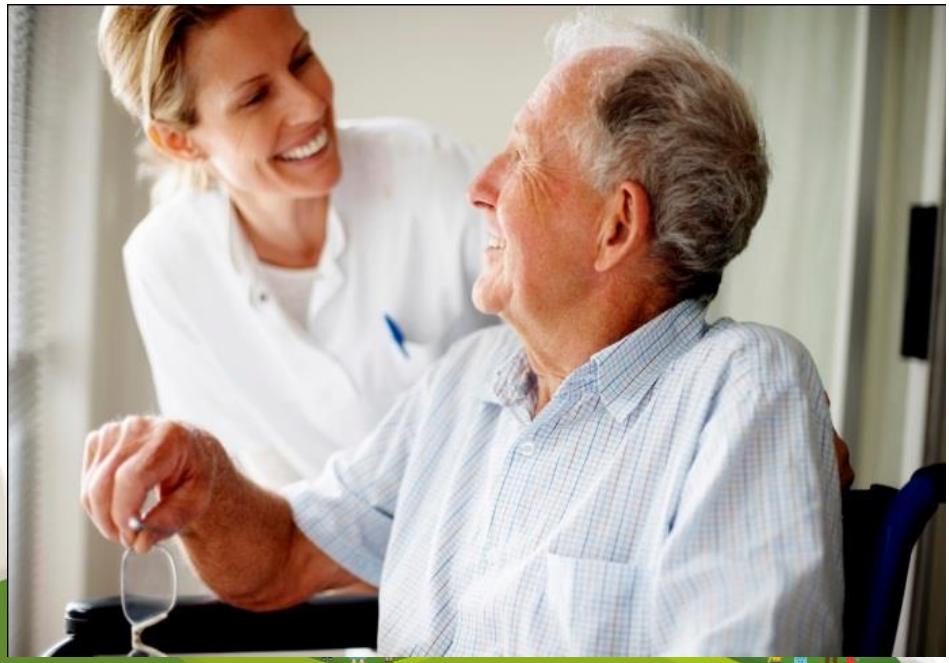
Anticipatory Care Planning Triggers: Situation

“

- Long term housebound
- Complex care package or in receipt of respite care
- Entry to care home or community hospital
- Unplanned admission
- Frequent unscheduled contacts
- Carer stress

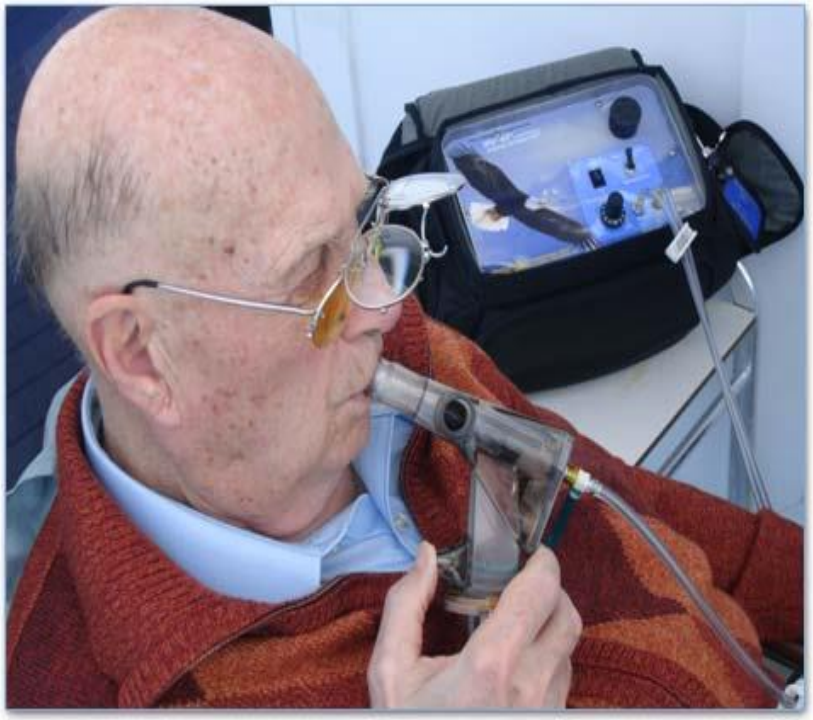
Assessment

- SPARRA or other risk prediction tools eg. Lifecurve
- Polypharmacy
- Falls assessment
- Recognised as vulnerable
- Clinical Judgement
- Local intelligence



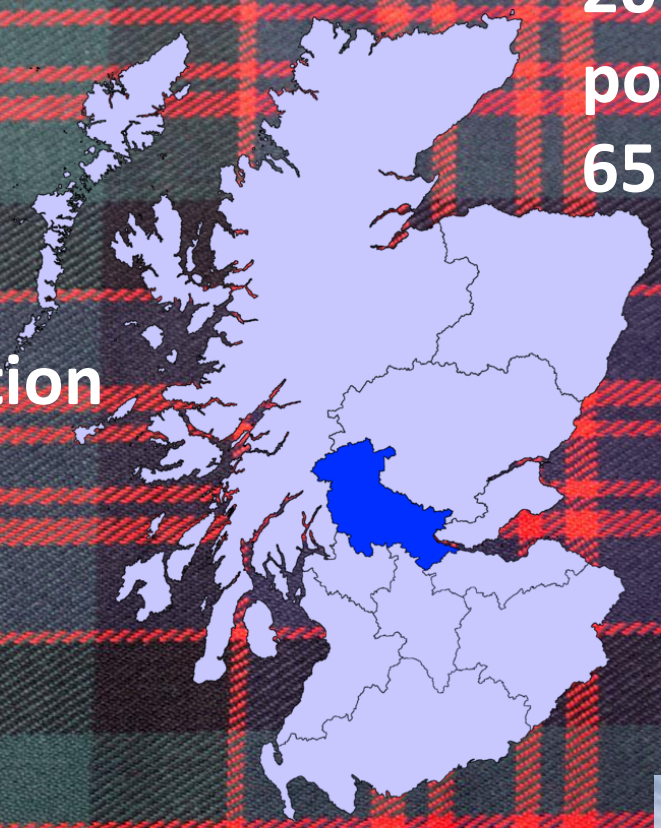
Condition

- Deteriorating long term condition
- Requiring specialist nurse
- Placed on palliative care , dementia, learning disability or mental health register



The need for change……

2015: 1 in 6 of the population aged over 65



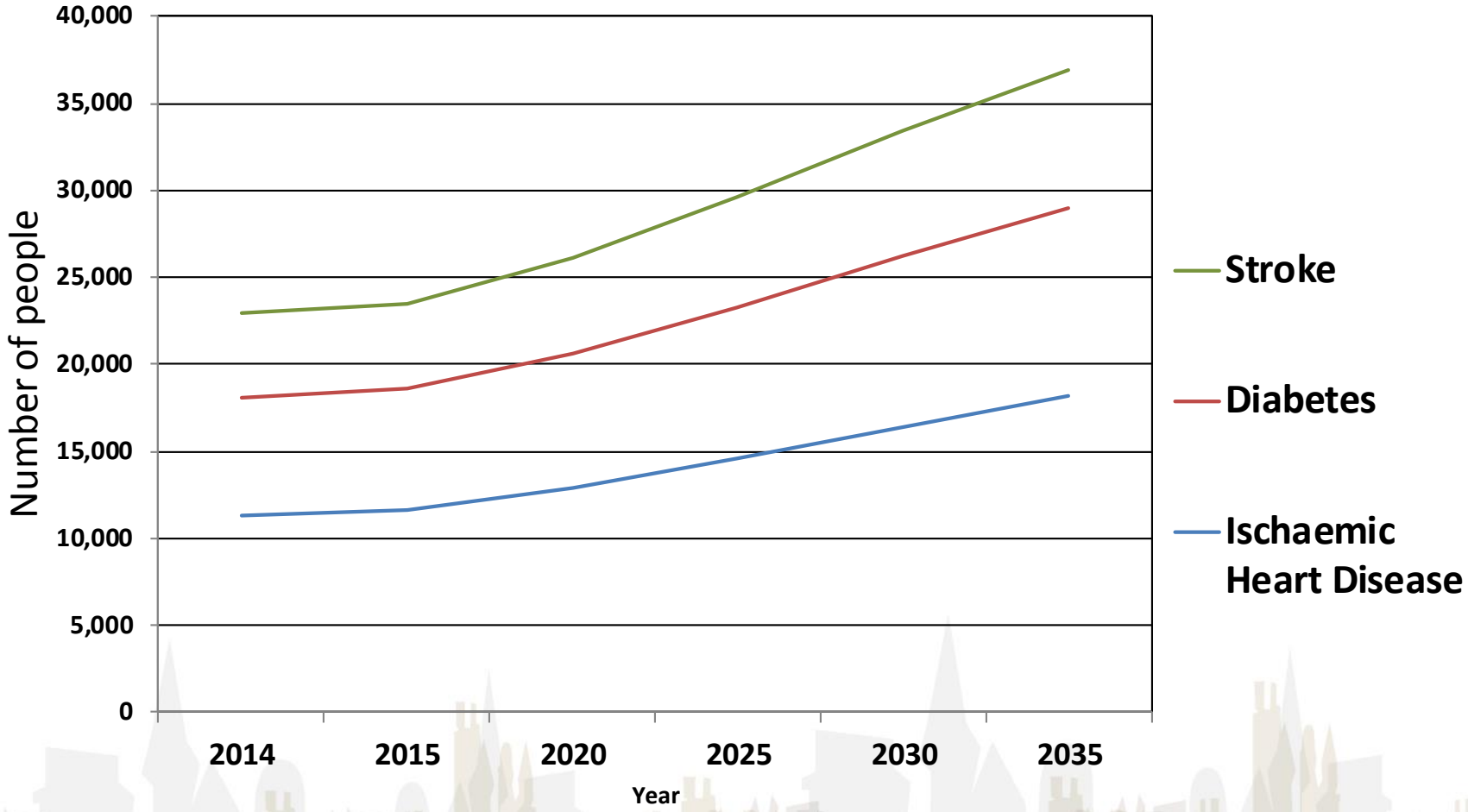
By 2035: 1 in 4 aged over 65

General population growth 12.5%

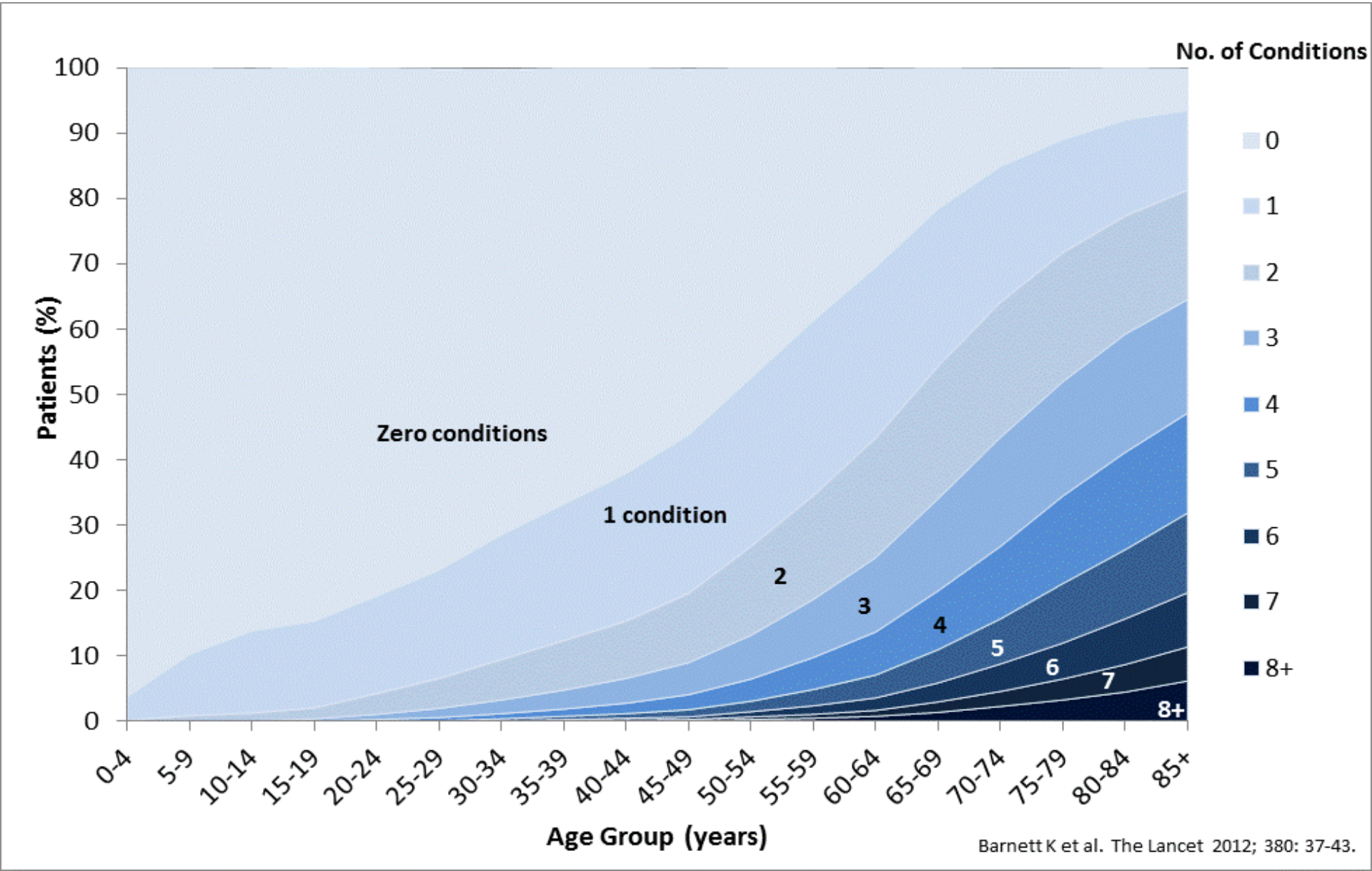
2015: 1 in 14 aged over 75

By 2035 : 1 in 8 aged over 75

Disease Prevalence

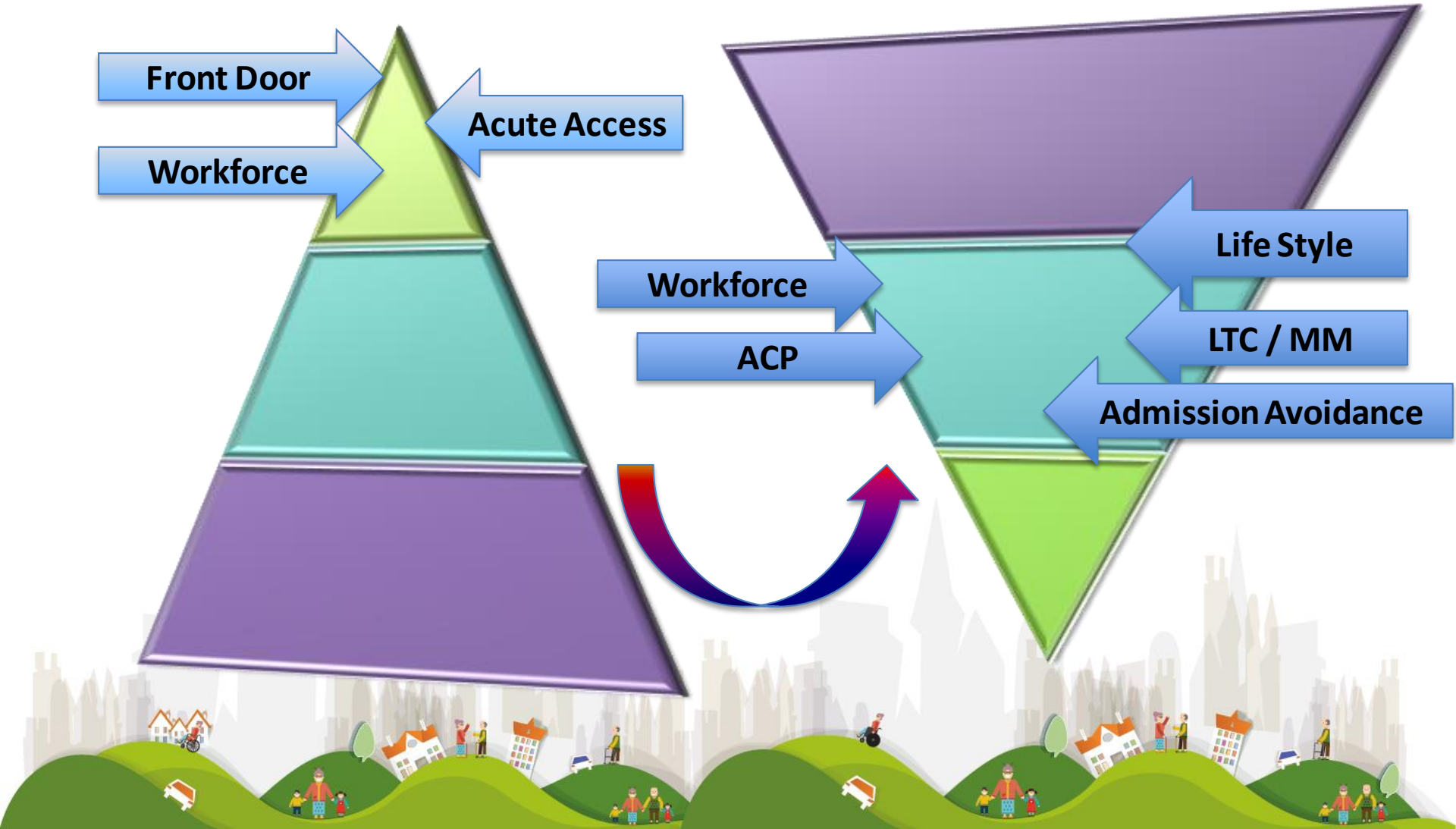


Multimorbidity and age



Barnett K et al. The Lancet 2012; 380: 37-43.

Getting the balance right



FROM POPULATION HEALTH TO LAST DAYS OF LIFE

WELL/AT RISK POPULATION
Health promotion and prevention, early detection and intervention, diagnosis and treatment

1

DIAGNOSED: MILD COMPLICATIONS OR IMPACT. CLIENTS CLINICAL INDICATORS ARE WITHIN ACCEPTABLE RANGE
Primary care, predominantly general practice based with referral to other PHC providers

2

DIAGNOSED: MILD COMPLICATIONS OR IMPACT. CLIENTS CLINICAL INDICATORS ARE NOT WITHIN ACCEPTABLE RANGE AND/OR THERE IS EVIDENCE THAT THE CLIENT IS NOT SELF MANAGING EFFECTIVELY
Predominantly general practice based with referral to other PHC providers.

3

MODERATE COMPLEXITY, SEVERITY OR IMPACT
Co-ordinated structured care provided by a responsive PHC interdisciplinary team. Clients case managed within general practice

4

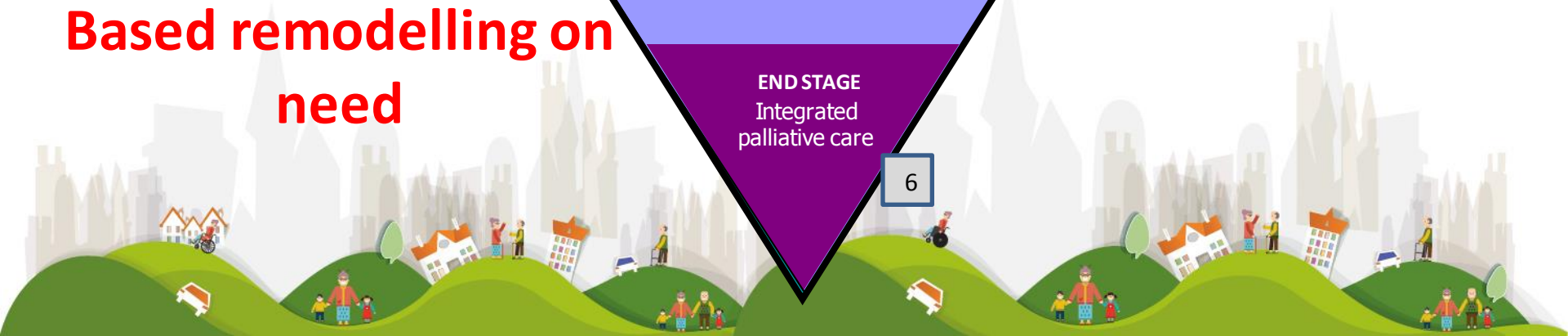
HIGH COMPLEXITY SEVERITY OR IMPACT
Integrated structured care provided by PHC interdisciplinary team in collaboration with Specialists. Clients case managed within General practice

5

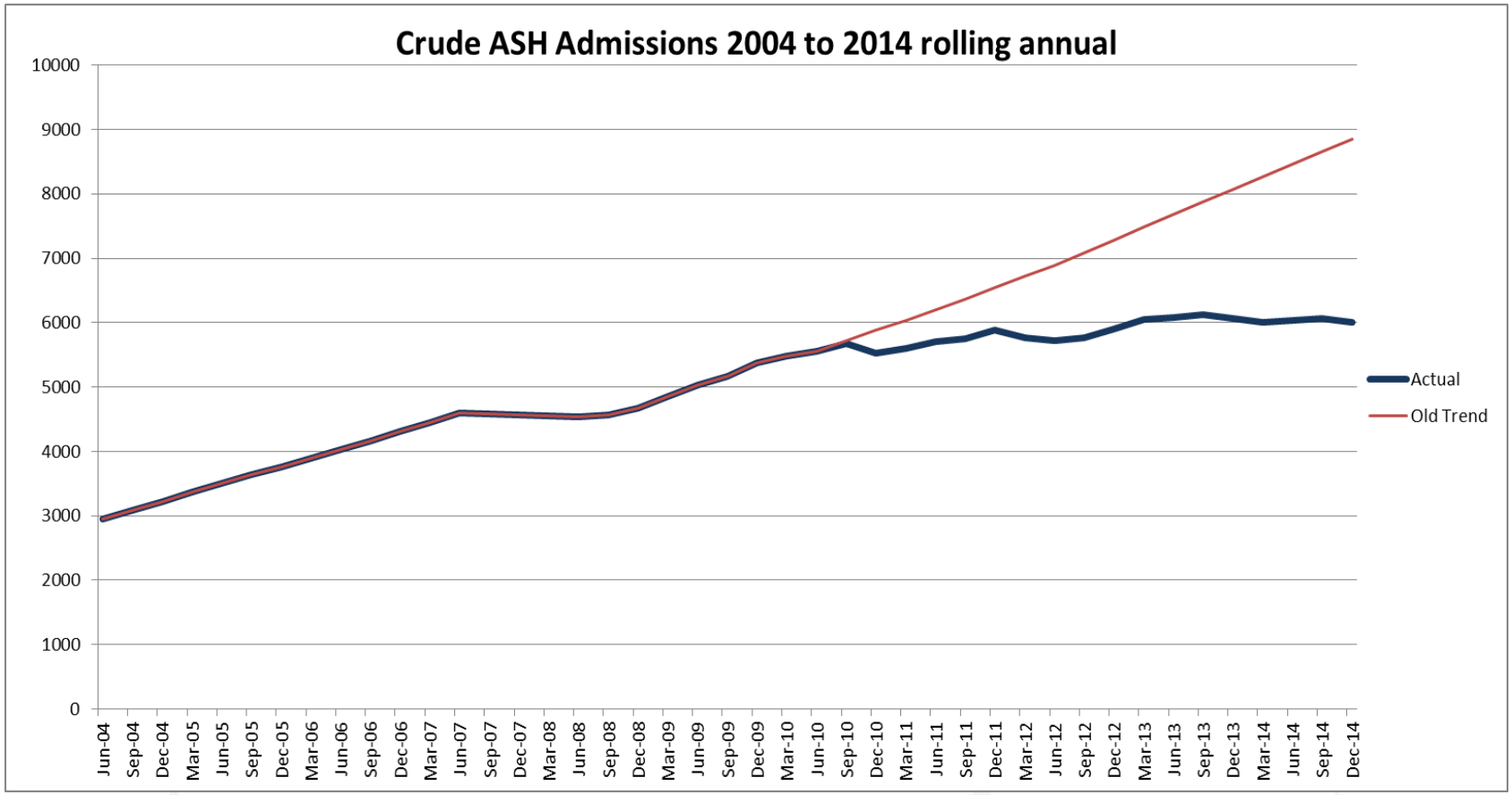
END STAGE
Integrated palliative care

6

Based remodelling on need



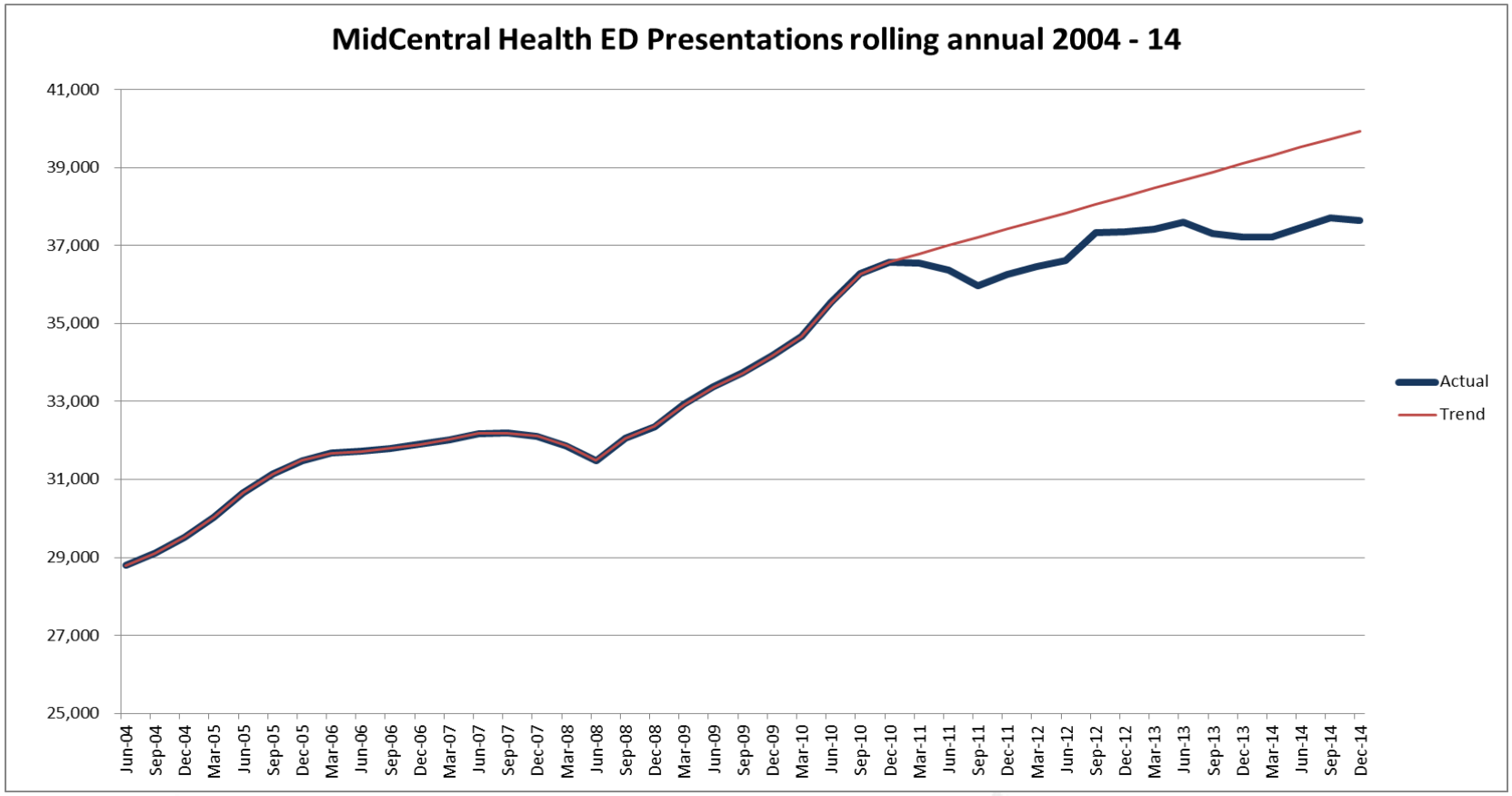
Supporting ACP in New Zealand



ASH rate (Ambulatory Sensitive Hospitalisations) rate for conditions where appropriate ambulatory (Primary) health care prevents or reduces the need for admission to hospital. People over age 75 are not categorised as ASH as age is then the major admission driver

MidCentral ASH Presentations			
		Current	
Pre 2010 trend line		8,847	pa
Current		5,999	pa
Potential reduction		2,848	pa
Valued at $5k per ASH		$5,000	per ASH
Savings to MidCentral		$14,237,989	pa

We (they!) have bent the curve



MidCentral ED Presentations		
	Current	
Pre 2010 trend line ED presentations	39,941	pa
Current annnual ED presentations	37,634	pa
Potential reduction	2,307	pa
Valued at $300 per ED marginal cost	$300	
Savings to MidCentral	$692,100	pa

Time to bring jigsaw together……

National Anticipatory Care Planning Task and Finish Group: Primary Drivers

1. Raise awareness and embed Anticipatory Care Planning within each Locality to help those with multiple morbidities
2. Work with partners to increase access of KIS
3. Work to ensure carer support aligned with ACP

Ensure delivery of ACP for all who would benefit

Awareness raising and improvement

- **Baseline scoping:**
  - Local leads within Boards/Partnerships
  - National ACP Programme Board

- **Focussed improvement:**
  - Develop logic models
  - Tests of change to inform future spread
  - Triggers, risk predictors
  - Test ACP documentation
  - Measure change:

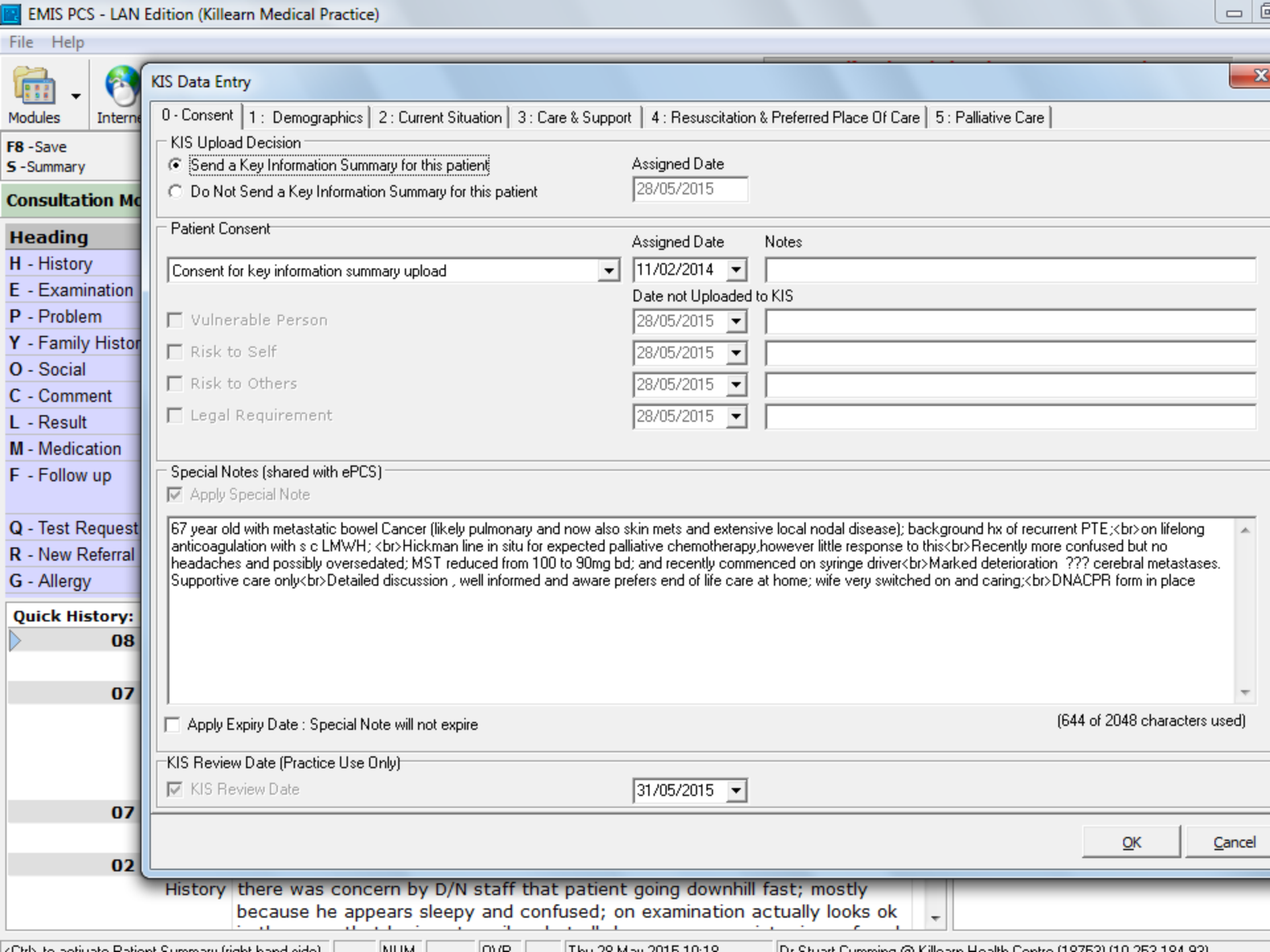
Proposed measures

- admission/readmission
- number of ACPs
- time during last 6 months of life in hospital
- workforce engagement
- Improved patient experience
- narrowing inequalities gap
- contribution analysis

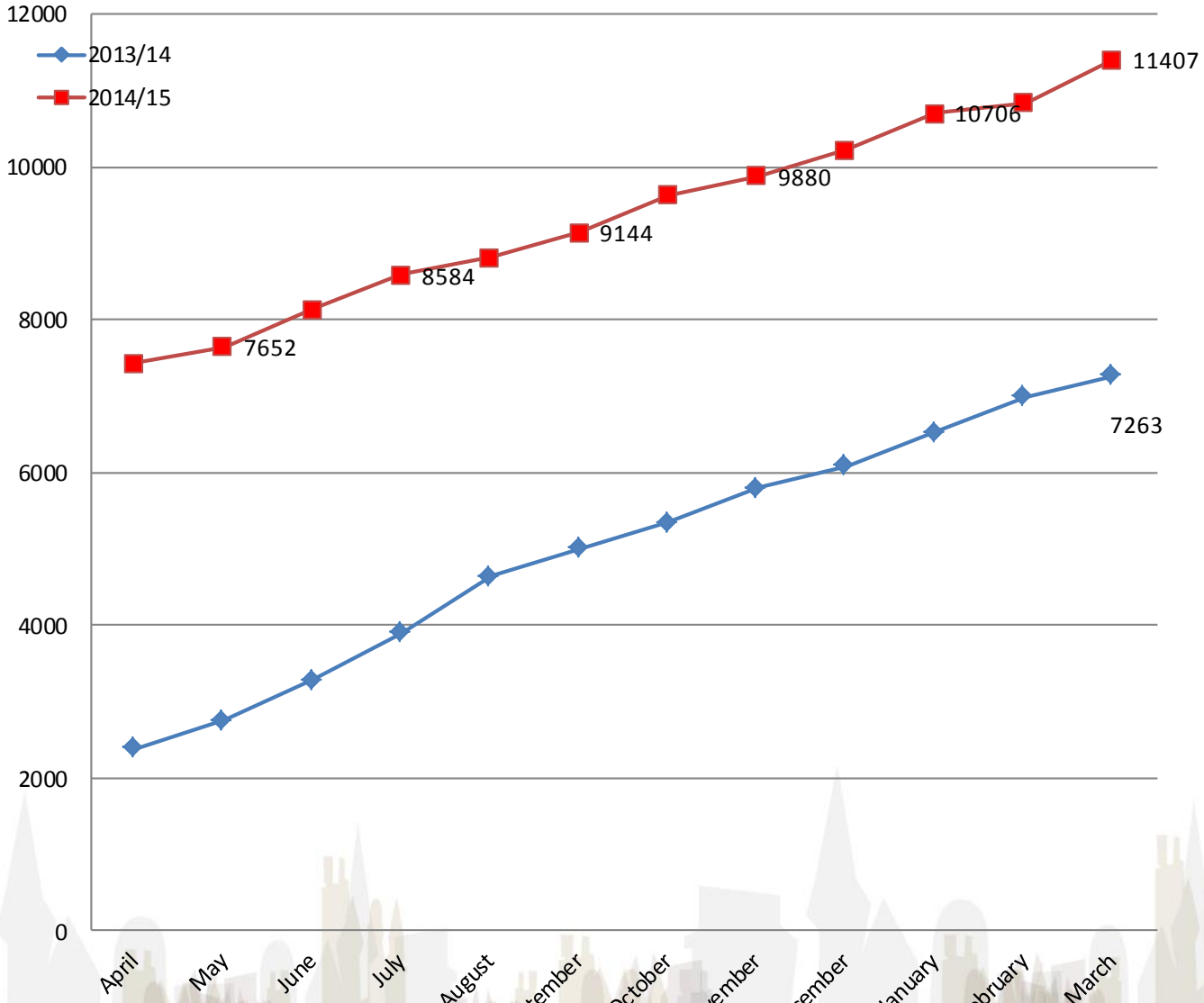
Growth and Change

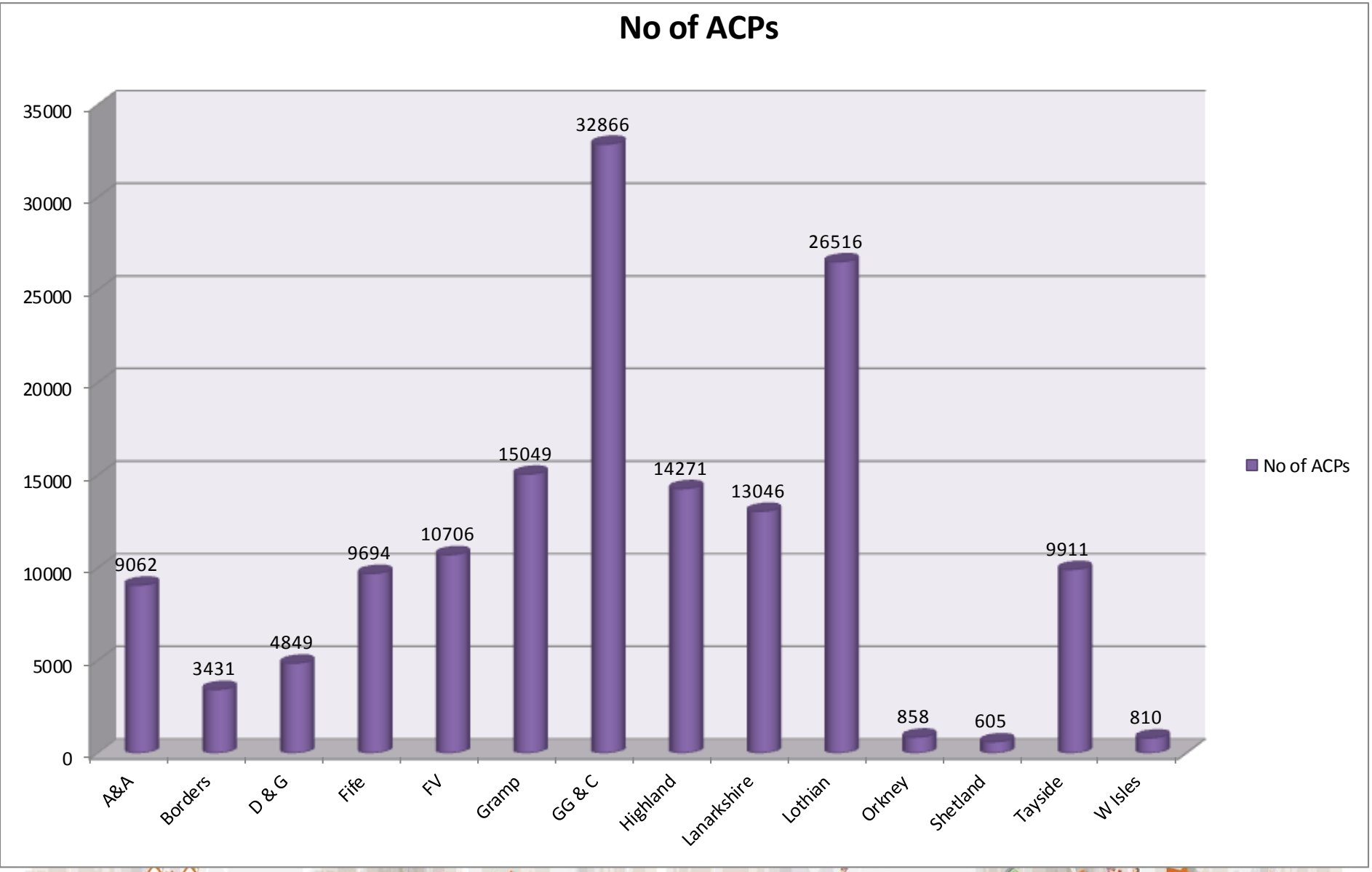
- Learning Needs Analysis to develop education programme
- Link with Technology Enabled Care Improvement Programme
- Improve use of eKIS
- Mobile Technology APP
- Raise Public Awareness and Communication Programme

Sharing Information with each other: Use of eKIS

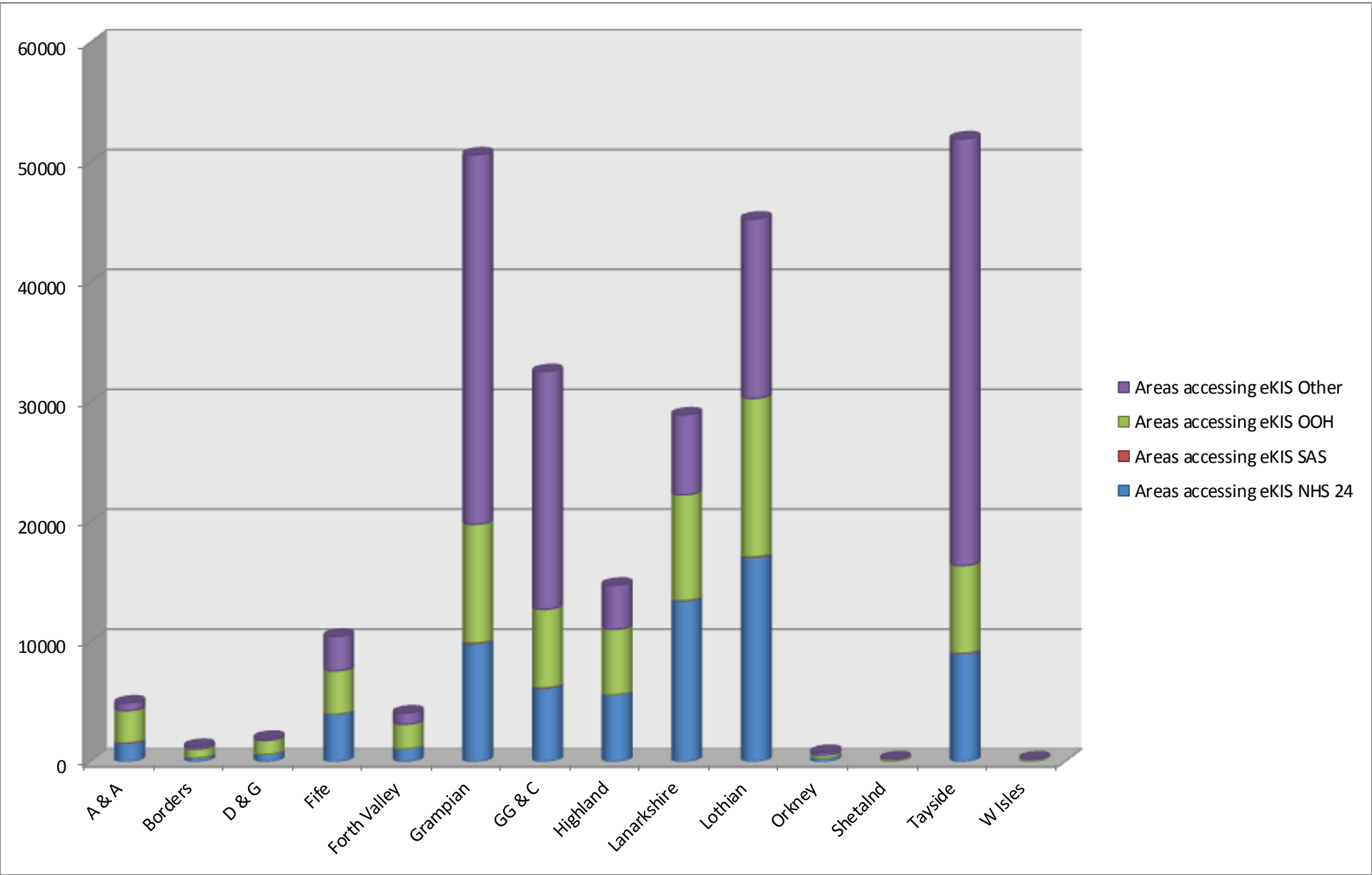

EMIS PCS - LAN Edition (Killearn Medical Practice)
File Help
Modules
F8 -Save
S -Summary
Consultation Mc
Heading
H - History
E - Examination
P - Problem
Y - Family Histor
O - Social
C - Comment
L - Result
M - Medication
F - Follow up
Q - Test Request
R - New Referral
G - Allergy
Quick History:
08
07
07
02
KIS Data Entry
0 - Consent
1 : Demographics
2 : Current Situation
3 : Care & Support
4 : Resuscitation & Preferred Place Of Care
5 : Palliative Care
KIS Upload Decision
Send a Key Information Summary for this patient
Do Not Send a Key Information Summary for this patient
Assigned Date
28/05/2015
Patient Consent
Assigned Date
Notes
Consent for key information summary upload
11/02/2014
Date not Uploaded to KIS
Vulnerable Person
Risk to Self
Risk to Others
Legal Requirement
28/05/2015
Special Notes (shared with ePCS)
Apply Special Note
67 year old with metastatic bowel Cancer (likely pulmonary and now also skin mets and extensive local nodal disease); background hx of recurrent PTE;
on lifelong anticoagulation with s c LMWH;
Hickman line in situ for expected palliative chemotherapy,however little response to this
Recently more confused but no headaches and possibly oversedated; MST reduced from 100 to 90mg bd; and recently commenced on syringe driver
Marked deterioration ??? cerebral metastases. Supportive care only
Detailed discussion , well informed and aware prefers end of life care at home; wife very switched on and caring;
DNACPR form in place
Apply Expiry Date : Special Note will not expire
(644 of 2048 characters used)
KIS Review Date (Practice Use Only)
KIS Review Date
31/05/2015
OK
Cancel
History
there was concern by D/N staff that patient going downhill fast; mostly because he appears sleepy and confused; on examination actually looks ok

NHS Forth Valley KIS/EPC Uploads




No of ACPs
35000
30000
25000
20000
15000
10000
5000
0
9062
3431
4849
9694
10706
15049
32866
14271
13046
26516
858
605
9911
810
A&A
Borders
D & G
Fife
FV
Gramp
GG & C
Highland
Lanarkshire
Lothian
Orkney
Shetland
Tayside
W Isles
No of ACPs

Specific Access in one month



Public Awareness

POA - Six Step Guide animation

My Power of Attorney

No matter what age you are it is important to talk about Power of Attorney and a good starting place is your parents or children. If this is not an option for you for any reason, you should talk to those closest to you. Everyday, thousands of people across Scotland need someone to act for them- to pay their bills, to make decisions about their care and to simply keep their best interests managed. Without Power of Attorney, the State will be appointed

Financial Power of Attorney explained

Jim Pearson discusses the importance of Power of Attorney for financial decisions.

Health and Power of Attorney :

Power of Attorney- Next of Kin

The Story behind the Ad: Irene


Whole System
Whole Person
Secondary Care
Nursing Team
Whole Team
ACUTE SERVICES NETWORK

Pathway 1

Social Care Notes
- £1200

Total Cost: £7,100

Social Care Assessment (1)
- By locality team
- Reablement
- Community alarm
- £600

Social Care Assessment (2)
- Crisis care home package
- 73 days
- Cost £3,400

May	June	July	August	September	October

Hospital Admission
- Emergency admission – hosp X - general medicine
- Abdominal swelling requiring minor intervention
- Discharge to own home
- 4 days
- £1,200

Outpatient
- GP referral
- Palliative medicine consultant
- Visit at home
- Cost £160

Death
- In the care home
- Liver cancer

GP Prescribing
- £500

Pathway 2

Hospital Admission 1
- Emergency admission – Hosp X – gen med
- Pneumonia
- 19 days
- Consult with Psychiatry and Palliative Care
- Transfer to community hospital
- 13 days (inc 10 days delayed discharge)
- Discharged to own home
- Cost £8800

Social Care Notes
- £300

Total Cost:
£18,000

Social Care Assessment (2)
- Short term care home placement
- 39 days
- Cost £1100

Social Care Assessment (1)
- Cost £150

July | August | September | October | November | December

Outpatient
- Consultant referral
- Hosp X
- Palliative medicine consultant
- £70

Hospital Admission 2
- Emergency admission (ambulance/ A&E) – Hosp X – general medicine
- Fall
- 1 day
- Transfer to Community Hospital
- 15 days (inc 12 days delayed discharge)
- Cost £4400

Hospital Admission 3 + Death
- A&E (via ambulance)
- Unplanned admission to Hosp X (gen med)
- Diagnosis of pneumonia
- After 3 days, patient dies
- Cost £900

GP Prescribing
- £150

See Change

Right action, Right person, Right place, right time...every time

Think ACP

Identify most vulnerable

Single ACP Accurate, timely hand-held

Improve KIS

Community capability and capacity

Carer Support

Improved interfaces

Communication and Information

Increased public awareness

An ACP for Scotland

Along with evidence....

Bit of blue sky thinking and a leap of faith

Additional focus needed on

- Technology
- From early intervention to end of life care
- Carers
- Workforce and cultural change
- Value of Collaboration
- Health Economics- Pathway

Are we bringing ingredients together correctly

to meet expectation and need….?